KANSAS PHYSICIAN/EMPLOYER REPORTING FORM

Please submit within the first thirty days of commencement of practice and yearly thereafter.

Physician:

Name: (please print) _____

Medical Practice Address: _____

_____

County _____ Phone # _____

I hereby declare and certify that I, the undersigned, have practiced _____
Specialty

medicine at the above-stated address a minimum of 40 hours per week since _____
Date: mo/day/year

_____ _____
Physician Signature Date

Answer this question only at the end of the third year of the 3-year contract:	I Will _____ I Will Not _____ (*check one*) remain in this location to practice medicine.

Employer:

I hereby declare and certify that Dr._____ is employed by

_____ at the above-stated address and provides at least

40 hours of _____ medicine per week.
Specialty

_____ _____
Signature Date

Subscribed and sworn to before me

this_____ day of_____, 20_____.

Notary Public